

450.60**Dual Participation****Prevention and Detection**

Introduction

The Iowa WIC program attempts to prevent WIC participants from receiving benefits from more than one agency in a month by requiring proof of identity and proof of residency as outlined in Policy 215.41. All Iowa WIC participants sign rights and conditions for participation that includes a statement that they understand they cannot get WIC foods from more than one clinic in the same month.

Dual participation is detected through electronic monitoring of in-state files and through agreements with bordering states to share participant information electronically or by phone when fraud is suspected.

**In-state
detection of
dual
participation**

A report is produced monthly that identifies all participants who have identical names, family identification numbers, or birth dates. Iowa WIC staff review electronic files of these participants and send information to both local agencies if there is an indication that the participant received and cashed benefits in both agencies in the previous month.

**Detection of
dual
participation
between states**

No individual with an address outside of Iowa is provided WIC benefits by Iowa WIC agencies unless the state in which the individual has residence is first contacted.

Copies of signed MOAs regarding exchanging participation information are on file at the State WIC office for Illinois, Minnesota, Missouri, Nebraska, South Dakota, and Wisconsin. A sample MOA can be found on page 3 of this policy.

Sanctions for Dual Participation

Unintentional dual participation	If the local agencies involved determine that the dual participation is unintentional, the participant shall be given their choice of agencies and terminated from the other agency.
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Intentional dual participation	If the local agencies involved determine that the dual participation is intentional the participant will be terminated from both programs and restitution sought according to Policy 225.80. The two agencies will jointly determine on a case-by-case basis which agency will impose sanctions and pursue any appropriate claims for restitution.

**MEMORANDUM OF AGREEMENT
BETWEEN THE *(State name)* STATE WIC PROGRAM
And THE IOWA STATE WIC PROGRAM**

PARTIES:

This Memorandum of Agreement (hereafter referred to as “MOA”) is made and entered into by and between the

(State) STATE WIC PROGRAM and the
IOWA STATE WIC PROGRAM

PURPOSE:

This MOA is for the purpose of preventing, detecting and sanctioning instances of dual participation.

INFORMATION EXCHANGE:

A comma delimited text file should be submitted on a diskette or CD to both parties.

(State) will submit the file to Iowa at this address:

Iowa Department of Public Health
Nutrition and WIC
321 East 12th Street
Des Moines, IA 50319-0075

Iowa will submit the file to *(State)* at this address:

(State) Department of Health
(Bureau)
Attn: *(Department Manager)*
(Address)
(City, State ZIP Code)

REPORTING PERIOD:

This agreement will be based on the federal fiscal year. Listed below are the last days of each report and also the last days that participant information should be exchanged:

<u>Semi-Annual</u>	<u>Last Day</u>	<u>Last Day to Submit Information</u>
First Half	March 31	May 15
Second Half	September 30	November 15

Participant information needs only to be processed for areas where factors make it likely for participants to travel regularly between contiguous service areas located across State agency borders as listed in federal regulations 246.7 (1), (1), (ii).

Iowa will send *(State)* participant information from the counties of: *(Bordering counties)*

(State) will send Iowa participant information from the counties of: *(Bordering counties)*

Either State may supply information of additional counties when there is a possibility of dual participation.

Field Seq.	Field Size	Positions	Field Title	Type	Comments
1	2	1-2	Participation category	A	I=Infant C=Child P=Pregnant woman B=Breastfeeding woman N=Non breastfeeding woman
2	15	3-17	Last name	A	
3	15	18-32	First name	A	
4	22	33-54	Street address	A/N	
5	14	55-68	City address	A	
6	2	69-70	State	A	Two letter Post Office Abbreviation
7	8	71-78	Date of birth	N	Actual Date MMDDYYYY
8	1	79	Sex	A	F=Female M=Male
9	8	80-87	Certification date	N	Actual Date MMDDYYYY
10	8	88-95	Last food benefit issue date	N	Actual Date MMDDYYYY
11	15	96-110	Guardian last name	A	
12	15	111-125	Guardian first name	A	

CONFIDENTIALITY:

Information exchanged in accordance with this Agreement shall be used or disclosed only in direct connection with the administration, enforcement and prosecution of violations of WIC regulations and procedures, except that such information may be disclosed to the controller General of the U.S. Department of Agriculture (USDA) and other authorized officials for audit and examination authorized by the law. Under no circumstances shall such information be disclosed to individuals or entities that are not involved in an official Program capacity, except as provided under 246.26(d)(1).

The method used to transfer all participant information will be such as to protect confidentiality. It is understood, however, that the use and sharing of participant information (individual and aggregate) within and across WIC State and local agencies is permissible under Program regulations at 7 CFR246.26(d) under the terms of this written agreement.

Documentation of activities pursuant to this agreement, including the disposition of all cases of dual enrollment and dual participation, shall be maintained on file in each of the involved State WIC Agency offices for audit and review purposes.

SANCTIONS:

Personnel from each State WIC office will compare the participant information submitted from the other state. If dual participation is discovered, the State agencies will jointly determine which agency will impose sanctions and pursue any appropriate claim on a case-by-case basis. At a minimum, participation will be terminated from one site immediately.

TERM OF THIS MOA:

This agreement shall be in effect as of the day and date of the last signature and executed by the duly authorized representatives of the parties of this MOA, and shall remain in full force and effect until terminated. Either party may terminate this MOA without cause upon thirty (30) days written notice. Notice shall be delivered by certified mail.

PAYMENT:

No payment shall be made to either party by the other party as a result of this MOA.

SIGNATURES:

In witness whereof, the parties to this MOA through their duly authorized representative have executed this MOA on the day and dates set out below, and certify that they have read, understood and agreed to the terms and conditions of this MOA as set forth herein. The effective date of this MOA is the date of the signature last affixed to this page.

(STATE) STATE WIC PROGRAM

(Authorized signature)
(Department)
(State Department of Health)

Date

IOWA STATE WIC PROGRAM

Judy Solberg, Bureau Chief, Nutrition
Iowa Department of Public Health

Date

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